

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01081

1075

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Price Station</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Price Station</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Cain</u> Last <u>Cain</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>81</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Viscose Prod.</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Anne Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Cain</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Cain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or date of service) <u>171-10-6239</u>		17. INFORMANT Address <u>Mrs. Fannie West, New York City, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis Generalized</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov 12, 1958</u> to <u>Jan 14, 1959</u> , that I last saw the deceased alive on <u>Jan 12, 1959</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Centreville, Md.</u> DATE SIGNED <u>1-16-59</u>							
ACTUAL SIGNATURE <u>C. Rodney Bayton</u> M.D.				PHYSICIAN'S NAME (Type) <u>C. Rodney Bayton</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/17/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Queen Anne County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. Sullivan</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1-16-59</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert A. Hanna</u>							

MEDICAL CERTIFICATION

1076 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grassonsville</u> c. LENGTH OF STAY IN 1b <u>all of life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grassonsville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Thomas</u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 7 - 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>24</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wagoner</u>	
11. BIRTHPLACE (State or foreign country) <u>Queen Anne's County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Carter</u>		14. MOTHER'S MAIDEN NAME <u>Melvinia Faddreack</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>19-03-7549</u>	
17. INFORMANT <u>Helen L. Carter, Grassonsville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>mitral regurgitation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>59</u> , to <u>Jan 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>59</u> , and that death occurred at <u>7:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Grassonsville Md</u> DATE SIGNED <u>1/3-59</u>			
ACTUAL SIGNATURE <u>W. A. Young Fisher</u> M.D. <u>Centerville Md</u>		DATE SIGNED <u>1/3-59</u>	
PHYSICIAN'S NAME (Type) <u>Deputy Med Exam for QAC Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 7 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brown Chapel Cemetery, Grassonsville Md</u>	22d. LOCATION (City, town, or county) (State) <u>Grassonsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Mulligan, Easton Md</u>		24a. REC'D BY REGISTRAR <u>JAN 6 1959</u>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE CERTIFICATE OF DEATH

DATE

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF URN

NAME OF CASK

NAME OF COFFIN

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Millington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresfield</u> 1939.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sally Wan Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>COLLISON</u> Last <u>COLLISON</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 31-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shuck Crystin</u>	
11. BIRTHPLACE (State or foreign country) <u>Cresfield Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert McCreedy</u>		14. MOTHER'S MAIDEN NAME <u>Sara Palmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT Address <u>Pauline McCreedy Cresfield Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Arterial Sclerosis</u> DUE TO (c) <u>Chronic Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Cerebralis Hemorrhage 15 no. 990</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>21</u> 19 <u>59</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9, 1959</u> to <u>Jan 25, 1959</u> that I last saw the deceased alive on <u>Jan 24, 1959</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. H. H. H. H.</u> M.D.		DATE SIGNED <u>Feb 25/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lawnside</u>		22d. LOCATION (City, town, or county) (State) <u>Cresfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. H. H. H.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 2 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Princess Anne</i>		c. LENGTH OF STAY IN 1b <i>6 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1413 S Liberty St</i>	
3. NAME OF DECEASED (Type or print) <i>JAMES LINWOOD FOWLER</i>		4. DATE OF DEATH <i>Jan 20 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 30 - 1873</i>
9. AGE (In years last birthday) <i>85 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>Worton, Kent Co Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Fowler</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Katherine Boyer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. Katherine Fowler Esquire, Clayton, Delaware</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 422.1 DUE TO <i>arteriosclerosis</i> (b) <i>arteriosclerosis</i> DUE TO <i>hypertension</i> (c) <i>hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 14 1959</i> to <i>Jan 20 1959</i> , that I last saw the deceased alive on <i>Jan 19 1959</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. F. McFerson</i>		DATE SIGNED <i>1/21/59</i>	
PHYSICIAN'S NAME (Type) <i>H. F. McFerson</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 23 59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Christ Episcopal</i>		22d. LOCATION (City, town, or county) (State) <i>Centerville Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Edward Bunting</i>		ADDRESS <i>Bethesda, Md</i>	
24a. REC'D BY REGISTRAR <i>Jan 23 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kenna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

1. Name of deceased: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of declarant: [illegible]
10. Date of statement: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 2 Millington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 2 Centerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mary Potts Nursing Home</u>		d. STREET ADDRESS <u>1 Burnsville</u>	
3. NAME OF DECEASED (Type or print) <u>KATIE BLAKE GARDNER</u>		4. DATE OF DEATH <u>Jan 1 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Do not know</u>
9. AGE (In years last birthday) <u>about 75 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Burnsville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emory Blake</u>		14. MOTHER'S MAIDEN NAME <u>Dolly Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fred Bayard S. Rt 2 Centerville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis / Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis (chr)</u> <u>Chr Arteritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 10 1958</u> to <u>Jan 1 1959</u> , that I last saw the deceased alive on <u>Dec 30 1958</u> , and that death occurred at <u>3:50 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		ADDRESS (Street, city or town, state) <u>Millington Md</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		DATE SIGNED <u>1/3/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Jan 4 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Burnsville</u>	22d. LOCATION (City, town, or county) (State) <u>Rt 2 Centerville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McEnroe Batts & Batts Inc</u>		ADDRESS <u>Centerville Maryland</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 7 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01086

1080

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Grasonville</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>DERIOUS</u> Last <u>Jerome</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 4 - 1862</u>	
9. AGE (In years last birthday) <u>96</u> yn		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN JEROME</u>				14. MOTHER'S MAIDEN NAME <u>PHOEBE COPPER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JACK GARDNER</u>		Address <u>CHESTER MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Chronic Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1958</u> to <u>Jan. 1959</u> , that I last saw the deceased alive on <u>Jan. 16</u> , 1959, and that death occurred at <u>4:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Grasonville, Ind.</u> DATE SIGNED <u>Jan 12/59</u>							
ACTUAL SIGNATURE <u>C. H. METCALFE</u> M.D.				PHYSICIAN'S NAME (Type) <u>C. H. METCALFE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 21</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS</u>		22d. LOCATION (City, town, or county) <u>QUEENSTOWN</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard Kane</u> ADDRESS <u>Church Hill, Ind.</u>				24a. REC'D BY REGISTRAR <u>JAN 22 59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Hanks</u>	



1081

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centerville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centerville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>127 B # 3</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>JAMES HARRY LARRIMORE</i>		4. DATE OF DEATH Month Day Year <i>Jan 13 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 17-1870</i>
9. AGE (in years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Queen Anne's Is Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Larrimore</i>		14. MOTHER'S MAIDEN NAME <i>Angie E Costen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Henry Larrimore</i>		Address <i>Centerville Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Valvular disease of the heart</i> <i>421.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1 1958</i> to <i>Jan 13 1959</i> that I lost saw the deceased alive on <i>Jan 12 1959</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H.F. McTherson</i> M.D.		ADDRESS (Street, city or town, state) <i>Centerville Md</i>	
PHYSICIAN'S NAME (Type) <i>H.F. McTherson</i>		DATE SIGNED <i>1-14-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Jan 15-59</i>	<i>Centerville</i>	<i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>St Francis Bldg, Eastern Boro Centerville Md</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 16 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fraser</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01088

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> <u>MARYLAND</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Grasonville - Rural</u> c. LENGTH OF STAY IN 1b <u>4 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent Narrows</u>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>425 West Sixth Street</u> e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Mae</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>19 59</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1932</u>					
9. AGE (In years last birthday) <u>26</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months Days	Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS						
Months Days	Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster House</u>					
11. BIRTHPLACE (State or foreign country) <u>Laurel, Delaware</u>		13. FATHER'S NAME <u>James Blango</u>					
14. MOTHER'S MAIDEN NAME <u>Aline Brock</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO. <u>215-26-5624</u>		17. INFORMANT Address <u>Mrs. Aline Brock, Laurel, Delaware</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral rupture of Abdominal Aorta</u> (b) <u>626X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. F. Methersoy</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>H. F. Methersoy</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>Jan. 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Zion Cemetery</u>					
22d. LOCATION (City, town, or county) (State) <u>Laurel, Delaware</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.J. Frampton and Son, Federalsburg, Maryland</u>					
24a. REC'D BY REGISTRAR <u>JAN 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Queenstown</u>		c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centerville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>Easton Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN DE BUTTS MOORE</u>			4. DATE OF DEATH Month Day Year <u>Jan 15 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17 - 1872</u>		9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Samuel Moore</u>			14. MOTHER'S MAIDEN NAME <u>Sara J Banbury</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Name Address <u>Mr Franklin Day Centerville Maryland</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Neck</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1-13 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>On highway</u>	20f. (City or town) <u>Queenstown</u>	(County) <u>RB DA Md</u>	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H. F. McPherson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-16-59</u>	
EXAMINER'S NAME (Type) <u>H. F. McPherson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Butler</u>		ADDRESS <u>Centerville Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kinn</u>

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR

1900

1. Name of Person *John Doe*

2. Sex *Male*

3. Age *25*

4. Date of Birth *Jan 15 1875*

5. Place of Birth *New York City*

6. Date of Death *July 10 1900*

7. Cause of Death *Heart Disease*

8. Signature of Registrar *[Signature]*

9. Signature of Physician *[Signature]*

10. Signature of Coroner *[Signature]*

11. Signature of Burial Officer *[Signature]*

12. Signature of Minister of Religion *[Signature]*

13. Signature of Undertaker *[Signature]*

14. Signature of Mortician *[Signature]*

15. Signature of Embalmer *[Signature]*

16. Signature of Funeral Home *[Signature]*

17. Signature of Cemetery *[Signature]*

18. Signature of Interment *[Signature]*

19. Signature of Burial *[Signature]*

20. Signature of Cremation *[Signature]*

21. Signature of Other *[Signature]*

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1084 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DA Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence, before admission) a. STATE <u>MD</u> b. COUNTY <u>DA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Millington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael E Oberholzer</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1954</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25-1896</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mexico City, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ruben Mc Laughlin</u>				14. MOTHER'S MARDEN NAME <u>Lula Mangel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Chas J. Oberholzer</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. F. Matherson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. F. Matherson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 23/1954</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cem.</u>		22d. LOCATION (City, town, or county) <u>White Marsh, Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellows</u>				ADDRESS <u>Millington Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knapp</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Family History		Social History		Clinical History		Laboratory Findings	
Autopsy		Disposition of Body		Burial		Remarks	